

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12051

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 220 PACA STREET CUMBERLAND</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>FRANK JOHN AMAN</b> First Middle Last <b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>4/2/83</b> <b>9. AGE</b> (In years last birthday) <b>78</b> <b>11</b> <b>30</b> <b>181</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Gardener (Retired)</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>City of Cumb.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN AMAN</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA BROOKS</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Mrs. Clara A. Aman</b> <b>220 Paca St., Cumb.</b> <b>Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Long Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Phlebotomy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Within 2 weeks</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct 1</b> <b>1966</b> <b>to</b> <b>Nov 30 61</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>11/30</b> <b>1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>B. M. Schindler</b> <b>M.D.</b> <b>22b. DATE SIGNED</b> <b>12/1/61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. B.M. SCHINDLER</b> <b>22d. ADDRESS</b> <b>43 GREENE STREET</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Dec. 4, 1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Patrick's Cem.</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George, Cumberland, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>DEC 5 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>	

1905

CERTIFICATE OF DEATH

1905

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b> d. STREET ADDRESS <b>301 PULASKI STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle <b>WILLIAMS</b> Last <b>AMSTUTZ</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 12, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WALTERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <b>Generalized Atherosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-9-61</b> to <b>11-12-61</b> that (I) (we) last saw the deceased alive on <b>11-11-1961</b> and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Williams</b> M.D.		22b. DATE SIGNED <b>11-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
ADDRESS <b>Cumberland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

1905

ALLIANCE

ARTISTS

CUMMINGS

3 DAYS

CUMMINGS

1301 PULASKI STREET

MEMORIAL HOSPITAL

NOVEMBER 15

JANE WILLIAMS

DEPT. 15, 1900

X

WHITE

U.S.A.

MARYLAND

HOUSEWIFE

ELIZABETH WALTERS

GEORGE WILLIAMS

MEMORIAL HOSPITAL - CUMMINGS, MARYLAND

*General Hospital*

*Memorial Hospital*

*Memorial Hospital*

11-12-01

11-11-01

11-11-01

127 S. CENTRAL STREET, CUMMINGS, MD.

DR. W. F. WILLIAMS

SPRINGFIELD, MARYLAND

SPRINGFIELD, MARYLAND

SPRINGFIELD, MARYLAND

SPRINGFIELD, MARYLAND

NOV 15 1900

CUMMINGS, MARYLAND

John J. Baker





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VR A15 (4)  
15M 9/60

DR. LEY

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12066

CERTIFICATE OF DEATH

12053

Item 8 Film G-302 12/13/61 iwk

1. PLACE OF DEATH a. COUNTY <i>Allegheny County</i> MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY in 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL AVE., CUMBERLAND, MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>GARRETT</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MARYLAND d. STREET ADDRESS 11X-2 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARTHA J. BEEMAN		4. DATE OF DEATH Month NOVEMBER Day 30 Year 1961		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 DEC. 14/1891		9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? US U.S.			
13. FATHER'S NAME BITTINGER, LEVIE				14. MOTHER'S MAIDEN NAME BESSIE TROUT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Coronary Occlusion</i> (c) <i>Arteriosclerotic cardiac - Valve lesion</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH Minutes years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 25</i> , 19 <i>61</i> , to <i>Nov 30</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Nov 30</i> , 19 <i>61</i> , and that death occurred at <i>7:20 PM</i> on the causes and on the date stated above.															
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 12/2/61							
22c. PHYSICIAN'S NAME (Type) <del>DR. G. O. HIMMELWRIGHT</del>				22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12/4/61		23c. NAME OF CEMETERY OR CREMATORY DURST		23d. LOCATION (City, town or county) (State) GRANTSVILLE GARRETT CO MD							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Don Newman</i>				ADDRESS Grantsville, Md		25a. REC'D BY REGISTRAR DATE DEC 7, '61		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>							

13003

13003



GENERAL HOSPITAL, CO. 100, 101

CHATTANOOGA, TENN.

23 DAYS

GENERAL HOSPITAL, CO. 100, 101

NOVEMBER 30, 1918

DEATH

U.S.

WHITE

WHITE

U.S.A.

CHATTANOOGA

ATTENDING, LIAISON



DR. RAY, C.O. HENDERSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 3 Film G302 12/4/61 iwk

12054

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BLOOMINGTON, MARYLAND</b>	
c. LENGTH OF STAY IN lb <b>22 days</b>		d. STREET ADDRESS <b>11X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAVID W. BEAVER</b>		4. DATE OF DEATH <b>11 22 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-90</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>WILLIAM S. BEAVER (D)</b>	
14. MOTHER'S MAIDEN NAME <b>LAVENA BEAVER(D)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>CHART</b>		17. INFORMANT <b>CHART</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO (b) <b>Adenocarcinoma stomach with</b> DUE TO (c) <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-31-61</b> , to <b>11-22-61</b> that (I) (we) last saw the deceased alive on <b>11-19-61</b> , and that death occurred <b>11-20-61</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl R. Paul</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EARL R. PAUL M. D.</b>		22d. ADDRESS <b>36 GREENE STREET CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Oakland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Earl R. Paul</b> ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12068

12055

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> <span style="float: right;"><b>L WEEK</b></span> c. LENGTH OF STAY IN 1b <b>L WEEK</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 1, FROSTBURG</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>MINNIE S. BRODE</b>				<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>22ND</b> Year <b>1961</b>													
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JULY 19TH, 1896</b>		<b>9. AGE (In years last birthday)</b> <b>65 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOUSEWORK</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>WILLIAM SITTIG</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>MINNIE BRODE</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>MRS. WM. BRODE, JR., FROSTBURG, MD.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> <b>FROSTBURG</b>		<b>(County)</b> <b>ALLEGANY</b>		<b>(State)</b> <b>MARYLAND</b>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Nov 21 1961</b> to <b>Nov 22 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 21 1961</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>W O McLane</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>Nov 22 1961</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>W. O. McLane</b>						<b>22d. ADDRESS</b> <b>167 E. MAIN ST., FROSTBURG, MD.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>11-24-61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>F'BG. MEMORIAL PARK</b>				<b>23d. LOCATION</b> (City, town or county) <b>FROSTBURG, MD.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. R. Burst</b>														<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 27 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



12008

12055

ALLIANCE

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1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12066

Item 1 Film G302 12/6/61 iwk

12056

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Little Orleans</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STENNIERS RUN</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Box 254 Rt 15</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VERNON H. CARR SR.</u>		4. DATE OF DEATH <u>Nov. 18TH 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR-7-1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO BUSSINESS RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PERRY CARR</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE P</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-34-9331</u>	
17. INFORMANT <u>HOWARD CARR (SON)</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>--</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Balto Co. Md.</u>	
23. FUNERAL DIRECTOR <u>John G. Connolly</u>		24a. REC'D BY REGISTRAR <u>NOV 27 '61</u>	
ADDRESS <u>418 Eastern Blvd Balto 21</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

1908

1908

1908

(M)

(1)

*[Faint, mostly illegible handwriting throughout the page, possibly representing a list or ledger entries.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12070						12057					
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgeley,</b> <b>85X-3</b> d. STREET ADDRESS <b>7 Martin St.,</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Bernard Morgon Clarke</b>						4. DATE OF DEATH <b>Nov. 22, 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1889</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Clarke</b>				14. MOTHER'S MAIDEN NAME <b>Eleanora Morgon</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <b>232-09-5878</b>				17. INFORMANT <b>Mrs. Elizabeth O. Stogdale</b>				Address <b>Hyattsville, Md. 4233 Oglethorpe St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the rectum</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cancer of the bladder</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3-4-1961</b> to <b>11-22-1961</b> , that (I) (we) last saw the deceased alive on <b>11-21-1961</b> , and that death occurred at <b>3:30A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>L. Brings</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Lewis Brings M. D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>57 Greene St., Cumberland, Md.</b> 22b. DATE SIGNED <b>Nov. 22, 1961</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 24 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12071

12058

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9/14/1961</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>34 Grand Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Alberta</b> Last <b>Colbert</b>				4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/18/1888</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Clarence Slippey</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Reitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, decompensating</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/14/61</b> 19____ to <b>11/6/61</b> 19____, that (I) (we) lost <b>saw the deceased alive on 11/4/61 @ 6:30 P.M.</b> and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>		22b. DATE SIGNED <b>11/6/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mc Intyre Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Holidaysburg, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

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Chamberland

9/11/1961

Chamberland

Allegany County Jail

Allegany County Jail

34 Grand Avenue

Julia

Albera

Robert

November 6

61

White

Female

2/18/1968

73

Honolulu

Honolulu

U. S. A.

Allegany County Jail

Allegany County Jail

P.O. Box 229

Allegany County Jail Records

11/6/61

11/6/61

11/6/61

8:30 P.M.

11/6/61

X

X

X

Dr. J. B. Johnson

12 Greene St., Chambersburg, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12072						12059					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Allegany			Frostburg			Maryland			Midland		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Miners Hospital											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
MARGARET COLEEN COLMER						11/25/1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6/28/1939		22 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Clerk				Store				Vale Summit, MD.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Britt Buckalew				Mary Hansel				U.S.A			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				212-38-5814				Harry Colmer			
								Midland, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>											
410X DUE TO (b) <u>Rheumatic heart disease with mitral stenosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>8 years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<u>Myocarditis - Acute Liver Congestion &amp; jaundice</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
20d. INJURY OCCURRED											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 1961, to Nov. 25, 1961, that (I) (we) last saw the deceased alive on Nov. 25, 1961, and that death occurred at 9 p.m. from the causes and on the date stated above.											
22a. SIGNATURE <u>L.R. Miles Jr.</u> M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR., M.D.</u>											
22d. ADDRESS <u>LONACONING, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

GEORGE EICHORN

LONACONING, MD.

NOV 29 '61

William S. Huns

1955

CONTRACT OF SALE

1955

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11/25/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12073  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12060

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>12 HRS. 6 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>7-D JANE FRAZIER VILLAGE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NOEL PATRICK CONLEY</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 7, 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-1961</b>
9. AGE (In years last birthday) <b>12</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>12 6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MD.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>NOEL CONLEY</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MAE CROSS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to Aspiration of blood</b> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intrauterine bleeding due to Abruptio Placenta</b> DUE TO (c) <b>12hrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7 Nov. 1961</b> to <b>7 Nov. 1961</b> , that (I) (we) last saw the deceased alive on <b>7 Nov. 1961</b> , and that death occurred at <b>7:25 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Leland B. Ransom</b> 22c. PHYSICIAN'S NAME (Type) <b>DR. LELAND B. RANSOM</b>		22b. DATE SIGNED <b>8 Nov 61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>63 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/9/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILL CREST BURIAL PARK</b>	23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 10 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

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12073

ALLIANCE

CLUBBING

REPORT & HAZARD AVEG.  
MEMORIAL HOSPITAL

WELL

WATKINS

CONLEY

WINTER 1941

WHITE

11-7-1941

CLUBBING, D.

U. S. A.

HILL CONLEY

ANNIE HILL CROSS

MEMORIAL HOSPITAL - 12073

MEMORIAL HOSPITAL - 12073  
MEMORIAL HOSPITAL - 12073

11-7-1941

U. S. A. 12073

U. S. A. 12073

U. S. A. 12073

U. S. A. 12073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12074 CERTIFICATE OF DEATH 12061											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>				d. STREET ADDRESS <b>362 Williams St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>362 Williams Street</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Abel</b> Middle <b>M.</b> Last <b>Conner</b>						4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1878</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kingwood, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Conner</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Burns</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If assigned war or dates of service)		17. INFORMANT Address <b>Mrs. F. De Sales King, Cumberland, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Thaemia</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b>arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>2 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9 1961</b> to <b>Nov. 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 9 1961</b> , and that death occurred at <b>11:40 P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/15/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>						22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Nov. 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Camp Ground Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Near Tunnelton, W. Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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*Very much improved*  
*the condition of*  
*the patient*

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12062											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Ridgeley,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hosp.</b>						d. STREET ADDRESS <b>Short Gap,</b>					
3. NAME OF DECEASED (Type or print) <b>Nennie Effie Culp</b>						4. DATE OF DEATH <b>Nov. 1, 19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 8, 1880</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>Greenland, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Charles Tucker</b>						14. MOTHER'S MAIDEN NAME <b>Susan Schell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No,</b>						16. SOCIAL SECURITY NO. <b>232-54-4606</b>					
17. INFORMANT <b>Mr. Dick Pownall</b>						Address <b>Rt. # 1 Ridgeley, W. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>											
DUE TO <b>Coronary sclerosis</b> (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <b>Rt. # 9 Cumb. Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Keyser, W. Va.</b>					
23. FUNERAL DIRECTOR <b>H. Wayne George</b> <b>Cumberland, Md.</b>						24a. REC'D BY REGISTRAR <b>NOV 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>			

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

12078  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
12063

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knapps Meadow</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> d. STREET ADDRESS <b>Knapps Meadow</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First <b>J.</b> Middle <b>CUTTER</b> Last		4. DATE OF DEATH <b>11/2/1961</b> Month <b>11</b> Day <b>2</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6/8/1891</b> 9. AGE (In years last birthday) <b>70</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Barbara Cutter</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War # 1</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Minnie Cutter, Lonaconing, MD.</b> (WIFE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Old Coney Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b> ADDRESS <b>LONA CONING, MD.</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

1508

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FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BEDFORD</b> <i>Allegheny</i> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN</b> <i>Cumberland</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN*near Cumberland, Maryland</b>						
c. LENGTH OF STAY in 1b <b>LIFETIME</b>					d. STREET ADDRESS <b>Cumberland, Maryland</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O. A. Memorial Hospital</b>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>DENNIS</b>			First		Middle		Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 61</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 27, 1961</b>		9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>DALE DARROW</b>					14. MOTHER'S MAIDEN NAME <b>NANCY MOWRY</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>HOSPITAL</b> Address <b>Cumberland, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, Bilateral</b> 4 90 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Several Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>NOVEMBER 11, 1961</b> DATE SIGNED Address (Street, city, town, or county) <b>Cumberland, Md.</b>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.											
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Frostburg, Maryland</b>			
23. FUNERAL DIRECTOR <b>John J. Hafer</b> Cumberland, Maryland				24a. REC'D BY REGISTRAR <b>NOV 16 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12078 CERTIFICATE OF DEATH 12065											
1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG,</b>				d. STREET ADDRESS <b>1 20 WASHINGTON ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>715 MARYLAND AVENUE</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARY T. DAVIS</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 3RD, 1874</b>		9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months <b>24</b> Days <b>12</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Housework</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PHILLIP THOMAS</b>						14. MOTHER'S MAIDEN NAME <b>MAGDELENA WEISENHEIMER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JOHN C. DAVIS, WASHINGTON ST., F'BG. MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute Cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Coronary occlusion</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>Had vaguinal repair 3 1/2 wks before</b> INTERVAL BETWEEN ONSET AND DEATH <b>few hrs.</b> <b>24 hrs.</b> <b>? yrs</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Oct 4, 1961</b> to <b>Nov 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 2, 1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. J. Mirkin M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-5-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. J. MIRKIN, M. D.</b>						22d. ADDRESS <b>115 S. CENTRE ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ZION CHURCH CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Burst</b>				ADDRESS <b>FROSTBURG, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

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PROTESTANT

ZION CHURCH CHRISTIAN

11-2-01

LOCAL

PROTESTANT, NO.

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A. J. MINNIN, N. D. 11-2-01

OFFICE OF THE

JOHN C. DAVID, WASHINGTON, D. C.

WILLIAM F. DAVIS

MICHAEL W. WILSON

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WILLIAM F. DAVIS

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# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12066

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>523 PEARRE AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ELLEN MAY DEETZ</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>NOV. 29 19 61</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SPET. 20, 1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PETER BRANT</u>		14. MOTHER'S MAIDEN NAME <u>LAURA STEIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. RUSSELL HOFF</u>		Address <u>CUMBERLAND, MD.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF <u>DEC. 2, 1961</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 29, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ZION MEMORIAL BURIAL PARK</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
22d. LOCATION (City, town, or country) (State)		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
23. FUNERAL DIRECTOR <u>BYRON KIGHT</u>		ADDRESS <u>CUMBERLAND, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 30 '61</u>		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12080						12067					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Allegany</b>						a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						b. COUNTY <b>Baltimore</b>					
c. LENGTH OF STAY IN 1b <b>1 Day</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>						d. STREET ADDRESS <b>3406 University Place</b>					
3. NAME OF DECEASED (Type or print) <b>Ralph C. Downey</b>						4. DATE OF DEATH Month <b>November</b> Day <b>10th</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11th, 1903</b>		9. AGE (In years last birthday) <b>58 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master Chemist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Davison Chem. Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Downey</b>						14. MOTHER'S MAIDEN NAME <b>Mayme Hoffman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>213-20-4058</b>				16. SOCIAL SECURITY NO. <b>213-20-4058</b>				17. INFORMANT <b>Joseph Downey, Frostburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>502.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic bronchitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from <b>11-9-1961</b> to <b>11-10-1961</b> , that (I) (we) last saw the deceased alive on <b>11-10-1961</b> , and that death occurred at <b>12:23 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>H.C. Diehl</b>						22b. DATE SIGNED <b>11/10/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>						22d. ADDRESS <b>FROSTBURG, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>				23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst</b>						ADDRESS <b>Frostburg, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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*[Faint, illegible handwriting]*

H. C. Diehl, M.D.

FROST B. C. M.D.



12081

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12068

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knapps Meadow</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY L. DUCKWORTH</b>		4. DATE OF DEATH <b>11/22/1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/31/1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New Germany, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Duckworth</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wiland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Joseph Crawford, Lonaconing, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial ischemia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic CV disease class III</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 2</b> 19 <b>56</b> , to <b>Nov. 22</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 9</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. R. Miles, Jr.</b>		22b. DATE SIGNED <b>11-24-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR., M.D.</b>		22d. ADDRESS <b>LONACONING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
ADDRESS <b>LONACONING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	

MEDICAL CERTIFICATION

1845



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12069

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>48 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>11 S. SMALLWOOD STREET</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>GERTRUDE L. ELLIOTT</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 15 19 61</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-9-1881</b>			
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>GEORGE G. AHN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH FREDERICK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or dates of service)					
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive arteriosclerotic vascular disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Onset 9-28-61</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dissecting</b>	
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
2Df. (City or town) <b>11-15-1961</b>				2Dg. (County) <b>Allegany</b>		2Dh. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>9-28-61</b> to <b>11-15-61</b> , that (I) (we) last saw the deceased alive on <b>11-15-1961</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. W. F. Williams</b>				22b. DATE SIGNED <b>11-16-61</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 18, 1961</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>				25a. REC'D BY REGISTRAR <b>NOV 20 61</b>					
ADDRESS <b>Cumberland, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

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BALTIMORE

MARYLAND

FOUNTERLAND

42 DAYS

CLERKLAND

11 S. SMITHSON STREET

HOSPITAL HOSPITAL

GEORGE J. ELLIOTT

WYOMING 12

10-9-1901

X

WHITE

FEMALE

PENNSYLVANIA

U.S.A.

ELIZABETH FRIEDMAN

GEORGE H. ARN

MEMORIAL HOSPITAL - COMMERCE, MARYLAND

*General Hospital*

*Hypertension with its effects on the heart*

4-22-11 11-12-11

11-12-11

*11-12-11*

12 S. CLARK STREET, COMMERCE, MD.

DR. W. F. WILLIAMS

*Dr. W. F. Williams, M.D.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12083  
CERTIFICATE OF DEATH

12070

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>37 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLOTHIAN</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>REGINA W EVANS</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 16 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20, 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL WEIMER</b>		14. MOTHER'S MAIDEN NAME <b>DELLA CROWE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>215-14-6594</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic insufficiency and failure</b> DUE TO (b) <b>Carcinomatosis</b> DUE TO (c) <b>Carcinoma of the cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>58</b> to <b>11/15</b> , 19 <b>61</b> , that (1) (we) last saw the deceased alive on <b>11/15</b> <b>161</b> , and that death occurred <b>7:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Lewis</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. LEWIS</b>		22b. ADDRESS <b>WASHINGTON &amp; CUMBERLAND ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F'BG.MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Hurst</b> ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

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ALLEGANY

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MEMORIAL HOSPITAL

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SHIRLEY WILSON

BERNARD

MIDDLEBURY

ST. DAVIDS

EVANS

MAY 20, 1907

MARTIN

USIA KANE

MEMORIAL HOSPITAL

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... of the ...*

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*Thomas F. Lewis*

THOMAS F. LEWIS

WASHINGTON CLINICAL ST., CUMBERLAND

2 DO. MENTAL PARK

HUTCHINSON

PROSSER, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12084

12071

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>23 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE.</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>LAWRENCE</b> Middle <b>A</b> Last <b>FANNON</b>		<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>26</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>10/27/85</b> <b>9. AGE</b> (In years last birthday) <b>76</b> yrs. <b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BANK PRESIDENT</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>FIRST NAT'L BANK</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>EDWARD FANNON</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ELLEN CUNNINGHAM</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>213-01-8004</b> <b>17. INFORMANT</b> <b>CHART</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> <b>420.1</b> DUE TO <b>Auricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary arteriosclerosis</b> <b>Ruptured duodenal ulcer (surgery 11/4/61); Uremia; Myocardial fibrosis;</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>10/25</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>10/25</b> <b>20f. (City or town)</b> <b>19 61</b> to <b>11/26</b> , <b>61</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>11/26</b> , <b>19 61</b> , and that death occurred at <b>9:30 A.</b> from the causes and on the date stated above.	
<b>21. I certify</b> that (1) (this hospital) attended the deceased from <b>11/26</b> , <b>19 61</b> , to <b>11/26</b> , <b>19 61</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>11/26</b> , <b>19 61</b> , and that death occurred at <b>9:30 A.</b> from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>DR. SAMUEL M. JACOBSON</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. SAMUEL M. JACOBSON</b> <b>22b. DATE SIGNED</b> <b>NOV 30 '61</b> <b>22d. ADDRESS</b> <b>50 PERSHING STREET</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>11-29-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Patricks</b> <b>23d. LOCATION</b> (City, town or county) <b>Mt. Savage - Alleg. - Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph R. Dunsen, 57 Frost Ave. Frostburg Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 30 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

12072

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY in 1b <u>Lifetime</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>R.</u> Last <u>FAYMAN</u>			4. DATE OF DEATH Month <u>November</u> Day <u>18.</u> Year <u>19 61</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1906</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Harry R. Fayman</u>			14. MOTHER'S MAIDEN NAME <u>Irene Stickle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>War II</u>	17. INFORMANT <u>Mrs. Harry Fayman, Cumberland, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRA*ABDOMINAL HEMORRHAGE</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>RUPTURE OF ARTERIOSCLEROTIC ABDOMINAL ANEURYSM</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH HOURS <u>"</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 18, 1961</u> DATE SIGNED Address (Street, city, town, or county) <u>Cumberland, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 20, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>James F. Scarpelli, Cumberland, Md.</u>			24a. REC'D BY REGISTRAR <u>NOV 22 '61</u>		
			24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>		

MEDICAL CERTIFICATION

12083

12083

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12086

12073

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WEST VIRGINIA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RT. # 1 RIDGELEY</b> d. STREET ADDRESS <b>85X3</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES H FISHER</b>		4. DATE OF DEATH Month <b>11</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/81</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired RR Worker Western Md. RR</b>		12. BIRTHPLACE (County & State, or foreign country) <b>MDX</b>	
13. FATHER'S NAME <b>William Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Valentine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-5609</b>	
17. INFORMANT <b>Carl J. Fisher, Cumb. Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and Chronic Congestive Heart Failure with anasarca and cerebral edema</b> DUE TO <b>Arteriosclerotic and Hypertensive CVD</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Obesity; age (80 yrs); cellulitis of both legs secondary to stasis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Obesity; age (80 yrs); cellulitis of both legs secondary to stasis</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		20. YEARS <b>Years</b>	
21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 4, 1961</b> to <b>November 6, 1961</b> that (I) (we) last saw the deceased alive on <b>November 6th 1961</b> , and that death occurred at <b>12:22</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. W. DOERNER</b>		22b. DATE SIGNED <b>11-7-61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>414 North Mechanic St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md</b>		25a. REC'D BY REGISTRAR <b>NOV 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krawe</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12087

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12074

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2/2/1958</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>89 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>A.</b> Last <b>Footen</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7,</b> Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 23-1889</b>		9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Footen</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Casey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Chronic, Degenerative</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mental Retardation</b> DUE TO (c) <b>Contractural Deformity, Lower Extremities</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/2/1958</b> 19____ to <b>11/7/61</b> 19____, that (I) (we) last saw the deceased alive on <b>11/6/61 @ 1:00 A.M.</b> and her death occurred at ____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/7/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montesant</b> <b>Frostburg, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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BP

13004

CERTIFICATE OF DEATH

13004

Allegany

Maryland

Allegany

(M)

Allegany County Infirmary  
39 Broadway  
Frederick, Maryland  
2/2/1958

None  
Female  
White  
Thomas  
Frederick, Maryland  
November 7, 1951

Thomas Rooden  
Charles County  
P.O. Box 277  
Allegany County Infirmary Records  
Frederick, Md.

11/7/51  
2/2/1958  
11/6/51 1:00 A.M.

Dr. Lee S. Stephens  
15 Greene St., Cumberland, Md.  
11/7/51

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

12088

12075

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Latrobe St.</b>		d. STREET ADDRESS <b>Latrobe St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>Henry</b> Last <b>Gallagher</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1961.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>	11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Gallagher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Agnes Gallagher-Barton, Md.</b>	
17. INFORMANT <b>Agnes Gallagher-Barton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lungs</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 16, 1961</b> to <b>Nov. 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 4, 1961</b> , and that death occurred at <b>5:30 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE <b>Nov. 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/7/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Barton Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. B. Cal</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

(M)

1800

CERTIFICATE OF DEATH

1800

DEPARTMENT OF HEALTH  
CITY OF NEW YORK

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]

Certificate of Death

Home

Nov 4 1900

Nov 4 1900

Paul A. [illegible]

X

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12089

12076

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>WINCHESTER ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>HENRY</b> Last <b>GRABENSTEIN</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRYMAN</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JULIUS GRABENSTEIN (D)</b>		14. MOTHER'S MAIDEN NAME <b>MARY MARTZ (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-1301</b>	
17. INFORMANT <b>Miss Mary Grabenstein Md.</b>		Address <b>Rt. #5, Cumberland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>generalized arteriosclerosis</b> (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-1-</b> , 19 <b>61</b> , to <b>11-28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-28-</b> , 19 <b>61</b> , and that death occurred at <b>11-29</b> , 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Brings</b>		22b. DATE SIGNED <b>11-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>		22d. ADDRESS <b>57 GREENE STREET CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Reuben H. Whitesant</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 &amp; 9 Film G300 11/14/61 iwk

Reg. ID No. 12090

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
c. LENGTH OF STAY IN lb <b>10 years</b>		d. STREET ADDRESS <b>506 Boyd Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Hartley</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1915</b> <b>Jan. 3, 1914</b>
9. AGE (In years last birthday) <b>47 1/4 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Keyser, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Winfield Scott Gray</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Beall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes War II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Raymond Gray, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC?, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Nov. 5, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 8, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarnelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATENOV 7 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clifford S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
12000

(M)

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Juror		11. Signature of Witness		12. Signature of Physician	
13. Signature of Nurse		14. Signature of Chaplain		15. Signature of Minister		16. Signature of Priest	
17. Signature of Rabbi		18. Signature of Imam		19. Signature of Priest		20. Signature of Minister	
21. Signature of Chaplain		22. Signature of Nurse		23. Signature of Physician		24. Signature of Medical Examiner	
25. Signature of Coroner		26. Signature of Juror		27. Signature of Witness		28. Signature of Physician	
29. Signature of Nurse		30. Signature of Chaplain		31. Signature of Minister		32. Signature of Priest	
33. Signature of Rabbi		34. Signature of Imam		35. Signature of Priest		36. Signature of Minister	
37. Signature of Chaplain		38. Signature of Nurse		39. Signature of Physician		40. Signature of Medical Examiner	
41. Signature of Coroner		42. Signature of Juror		43. Signature of Witness		44. Signature of Physician	
45. Signature of Nurse		46. Signature of Chaplain		47. Signature of Minister		48. Signature of Priest	
49. Signature of Rabbi		50. Signature of Imam		51. Signature of Priest		52. Signature of Minister	
53. Signature of Chaplain		54. Signature of Nurse		55. Signature of Physician		56. Signature of Medical Examiner	
57. Signature of Coroner		58. Signature of Juror		59. Signature of Witness		60. Signature of Physician	
61. Signature of Nurse		62. Signature of Chaplain		63. Signature of Minister		64. Signature of Priest	
65. Signature of Rabbi		66. Signature of Imam		67. Signature of Priest		68. Signature of Minister	
69. Signature of Chaplain		70. Signature of Nurse		71. Signature of Physician		72. Signature of Medical Examiner	
73. Signature of Coroner		74. Signature of Juror		75. Signature of Witness		76. Signature of Physician	
77. Signature of Nurse		78. Signature of Chaplain		79. Signature of Minister		80. Signature of Priest	
81. Signature of Rabbi		82. Signature of Imam		83. Signature of Priest		84. Signature of Minister	
85. Signature of Chaplain		86. Signature of Nurse		87. Signature of Physician		88. Signature of Medical Examiner	
89. Signature of Coroner		90. Signature of Juror		91. Signature of Witness		92. Signature of Physician	
93. Signature of Nurse		94. Signature of Chaplain		95. Signature of Minister		96. Signature of Priest	
97. Signature of Rabbi		98. Signature of Imam		99. Signature of Priest		100. Signature of Minister	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12091

12078

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>55 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>719 Memorial Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Ellen</b> Last <b>Grimm</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>86</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Armstrong Valley, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Warfel</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Dietrich</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Coretta Davis, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Myocardial Infarct.</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1961</b> to <b>Nov. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24, 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>H. W. Eliason M.D.</b> 22b. DATE SIGNED <b>Nov. 30, 1961</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. H. W. Eliason</b> 22d. ADDRESS <b>203 Greene St., Cumberland, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Dec. 1, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS 25a. REC'D BY REGISTRAR <b>DEC 4 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. France</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12092 CERTIFICATE OF DEATH 12079

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN TB <b>40 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>617 Elm St.</b>		d. STREET ADDRESS <b>617 Elm St.</b>	
3. NAME OF DECEASED (Type or print) <b>Juanita Mae Groves</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1921</b>
9. AGE (In years last birthday) <b>40 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Callie H. Burns</b>		14. MOTHER'S MAIDEN NAME <b>Ella Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Vernon Groves, Cumberland, Md.</b>	
17. INFORMANT <b>Mr. Vernon Groves, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma, generalized</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carcinoma Breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Nov 2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 1</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Carlton Brinsfield</b>		22b. DATE SIGNED <b>11-5-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Carlton Brinsfield</b>		22d. ADDRESS <b>232 Baltimore Ave. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 5, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12093											
12080											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>443 Henderson Ave.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u> d. STREET ADDRESS <u>1 443 Henderson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Anna C. Hart</u>						4. DATE OF DEATH <u>Nov. 18, 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John M. Hart</u>						14. MOTHER'S MAIDEN NAME <u>Christine Stark</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Ethel C. Rambo, Washington D.C.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> to <u>11/17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>61</u> , and that death occurred at <u>6:09 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Leo H. Ley Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR.</u>						M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/20/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>						23b. DATE THEREOF <u>11/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>DATE NOV 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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13081

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "March", "April", "May", "June", "July", "August", "September", "October", "November", "December" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

12094

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12081

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7/14/1961</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmiry</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Heath</b>		4. DATE OF DEATH Month Day Year <b>November 4, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1869</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Dispatcher Bus Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jonathan Heath</b>		14. MOTHER'S MAIDEN NAME <b>Mary Susan Orndorf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, degenerative, Senile -</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arterio-sclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/14/61</b> 19 to <b>11/4/61</b> 19, that (I) (we) last saw the deceased alive on <b>11/3/61</b> 19 @ <b>5:30 A.M.</b> and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>11/4/1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Moorefield, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 '61</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

12081

CERTIFICATE OF DEATH

12081

Allegheny

Allegheny

Allegheny

Allegheny

Allegheny

Allegheny

Allegheny County Infirmary

150 Greene Street

Charles

William

Heath

November 11

61

Male

White

X

11/15/1961

Residence: 150 Greene Street, West Virginia

West Virginia

Thomas Heath

Mary Susan Heath

P.O. Box 299

Allegheny

Allegheny County Infirmary Records

11/15/61 2:30 A.M.

11/15/61

11/15/61

Dr. Lee B. Matthews

150 Greene St., Allegheny, Pa.

Dr. Lee B. Matthews  
11/15/61  
Allegheny County Infirmary

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12093

12082

<b>1. PLACE OF DEATH</b> e. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>107 S. GEORGE ST.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>BOYD V. HILLIARD</b>				<b>4. DATE OF DEATH</b> Month <b>NOV.</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9, 1907</b>		9. AGE (In years last birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANERS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ROSSER HILLIARD</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE VANCE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-7546</b>		17. INFORMANT <b>PATIENT'S CHART</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>apoplectic stroke</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerosis</b> (c) <b>extension</b> DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-2-</b> , 19 <b>61</b> , to <b>11-5-</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-4-</b> , 19 <b>61</b> , and that death occurred at <b>11-5-</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Lewis Brings M.D.</b>				22b. DATE SIGNED <b>11-6-61</b>		22c. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>	
22d. ADDRESS <b>GREENE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HEBRON CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WINCHESTER, VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12083

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>8 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>103 Independence Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Independence Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Earl Hook Sr.</u>				4. DATE OF DEATH Month Day Year <u>November 23 19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1900</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B&amp;O R R Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Hook</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Warnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-3450</u>		17. INFORMANT <u>Clarence E. Hook Jr.</u> Address <u>Cumberland Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> -----
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Cumberland</u>	(County) <u>Maryland</u>	(State) <u>Maryland</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				DATE SIGNED <u>November 23, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

MEDICAL CERTIFICATION

13083

(M)

(1)

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse by certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

12097

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>60 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>225 Grand Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>M.</u> Last <u>Hout</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. To Chief Clerk Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Hout</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Harmison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-8166</u>		17. INFORMANT Address <u>Mrs. Joseph M. Dorsey, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> (c) <u>  </u> DUE TO (a) <u>  </u> (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Nov. 6, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF **12098** **12085**  
**CERTIFICATE OF DEATH**  
 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>65 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>430 Homer Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>430 Homer Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Famie Elizabeth Hoyle</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>22</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 9, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>65 yrs.</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cumberland, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John E. Squires</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Kiffner</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Mr. Howard Hoyle, Cumberland, Md.</u>			
<b>17. INFORMANT</b> <u>Mr. Howard Hoyle, Cumberland, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death 5 yrs</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>22</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Cumberland, Md.</u> <b>20f. (City or town)</b> <u>Cumberland, Md.</u> <b>(County)</b> <u>Allegany</u> <b>(State)</b> <u>Md.</u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/7/55</u> , 19 <u>55</u> , to <u>11/22/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/22/61</u> , 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>[Signature]</u> M.D. <b>22b. DATE SIGNED</b> <u>Nov 28 1961</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Cumberland Md</u> <b>22d. ADDRESS</b> <u>Cumberland Md</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov. 25, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Cumberland, Md.</u> <b>(State)</b> <u>Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James F. Scarpelli, Cumberland, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 28 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12088

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VS. A15ME  
5M 7/59

## 12086

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>119 Park Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>STATEN</b>		First <b>ISAAC</b>		Last <b>HOYLE</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH <b>Nov. 9, 1961</b>		9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carman</b>		12. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		13. BIRTHPLACE (State or foreign country) <b>Berkley Springs, W.VA.</b>	
14. FATHER'S NAME <b>John W. Hoyle</b>		15. MOTHER'S MAIDEN NAME <b>Virginia M. Miller</b>		16. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes,</b>		18. SOCIAL SECURITY NO. <b>W.W.# 1 705-05-8549</b>		19. INFORMANT <b>Mrs. Lucy O. Hoyle</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
28. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>		30. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Nov. 10, 1961</b> Address (Street, city, town, or county) <b>Rt. # 9 Cumberland Md</b>	
31. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		32. DATE THEREOF <b>11/12/61</b>		33. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>	
34. LOCATION (City, town, or country) <b>Cumberland, Maryland</b>		35. FUNERAL DIRECTOR <b>Charles L. George</b>		36. ADDRESS <b>Cumberland, Md.</b>	
37. REC'D BY REGISTRAR DATE <b>NOV 13 '61</b>		38. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

15086

15086



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12100											
12087											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
e. COUNTY <b>Allegany</b>						e. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowling Green, Cumberland, Md.</b>						b. COUNTY <b>Allegany</b>					
c. LENGTH OF STAY IN 1b <b>Years</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowling Green, Cumberland, Md.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>407 Bowling Ave., Bowling Green, Cumberland</b>						d. STREET ADDRESS <b>407 Bowling Avenue</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>LELA GOLDEN JONES</b>						4. DATE OF DEATH <b>November 4, 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 10, 1889</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Grafton, W.Va.</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Mortimer N. Utterback</b>						14. MOTHER'S MAIDEN NAME <b>Mary E. Gelhausen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Mr. Theodore A. Jones</b>						Address <b>Bowling Green, Cumberland, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Arterio Sclerotic Cardiovascular</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>About 1 yr.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland</b>		(State) <b>(State)</b>	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>July 6, 1960</b> to <b>Nov 4, 1961</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Oct 31, 1961</b> , and that death occurred at <b>5:AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. W.F. Williams</b>						22b. DATE SIGNED <b>11-4-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. W.F. Williams</b>			
22d. ADDRESS <b>122 S. Centre St., Md.</b>						22e. REC'D BY REGISTRAR <b>DA NOV 7 '61</b>					
22f. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, 202 Greene St., Md.</b>						25. REC'D BY REGISTRAR <b>DA NOV 7 '61</b>					

58081



121355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12088

1. PLACE OF DEATH a. <b>CUMBERLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN b <b>44 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL--CUMBERLAND</b> d. STREET ADDRESS <b>RT. # 1, HOMEWOOD ADDITION</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JACOB WALTER KEARCHNER</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 30, 1890</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>PENNA. FAIRHOPE</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOHN KEARCHNER (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN Spaugy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>PATIENTS CHART</b>			
17. INFORMANT <b>PATIENTS CHART</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>150X</b> DUE TO <b>Cause of the esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-1961</b> to <b>11-23-1961</b> , that (I) (we) last saw the deceased alive on <b>11-22-1961</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lewis Brings</b> M.D.				22b. DATE SIGNED <b>NOV 28 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, MD.</b>				22d. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oddfellows Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Flintstone, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 28 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							



ALLEGANY

WEST VIRGINIA

ALLEGANY

COUNTY

IN DAYS

RURAL--CUMBERLAND

SACRED HEART HOSPITAL

RT. 2, HUNTERDON ADDITION

JACOB

W. T. T. T.

KEA CHURCH

NOV.

23

1901

WHITE

XX

JULY 30, 1900

VI

USA

PENNA. INDIANA

JOHN REARCHEM (DECEASED)

ILLER

ALLEGANY

PATIENTS CHART

LEWIS HENRY, MD.

27 GREEN ST., CUMBERLAND, MD.

ALLEGANY COUNTY

MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12102  
CERTIFICATE OF DEATH  
10089

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>MT. SAVAGE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>J. ORVILLE KEFAUVER</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 14, 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 1, 1885</b>
9. AGE (in years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>public school</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MIDDLETOWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEWIS F. KEFAUVER</b>		14. MOTHER'S MAIDEN NAME <b>JOANNA V. COOKERLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Carcinoma of prostate</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11-9-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>11-9-61</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11-9-61</b> to <b>11-15-61</b> , that (I) (we) last saw the deceased alive on <b>11-9-61</b> , and that death occurred at <b>5:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard L. Tolson</b>		22b. DATE SIGNED <b>NOV 20 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>		22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/17/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Middletown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Shadell Co.</b>		25a. REC'D BY REGISTRAR <b>Middletown, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>NOV 20 '61</b>	

14103

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1

ALLEGANY

MARYLAND

ALLEGANY

MT. SAVAGE

2 DAYS

CHURCH

MEMORIAL HOSPITAL  
CHURCH & WARREN STS.

61

NOVEMBER 14,

KEYAUVER

ORVILLE

1

36

NOVEMBER 1, 1985

13

WHITE

MALE

U.S.A.

MIDDLETON, MARYLAND

JOHN V. COCKERY

LEWIS F. KEYAUVER

MEMORIAL HOSPITAL, CHURCH & WARREN STS., MD.

*Carcinoma of prostate*

✓

11-2-61

11-5-61

11-5-61

2:53 PM.

*Howard H. Tolson*

122 S. CENTRE STREET, CUPERTINO, MD.

DR. HOWARD L. TOLSON

100-100000-100

100-100000-100

100-100000-100

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100-100000-100

Item 18 Filed 301 11-17-61  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12103

12090

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>75 DAYS</b>				d. STREET ADDRESS <b>138 WEST THIRD STREET</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ZENA C. KESECKER</b>				4. DATE OF DEATH <b>NOVEMBER 15, 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-5-1911</b>	
9. AGE (in years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Undergarment Factory</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>AZORA L. BENNETT</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. BONNER BONNER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>215-20-6887</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Retroperitoneal lymphosarcoma</b> IMMEDIATE CAUSE (a) <b>200.1</b> DUE TO <b>Delayed Urinary Calculi</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Report</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 15 61 11:55 P.M.</b> to <b>NOV 15 61</b> , that (I) (we) last saw the deceased alive on <b>NOV 15 61</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. G. O. HIMMELWRIGHT</b>				22b. DATE SIGNED <b>11/16/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>				22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-18-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 17 '61</b>			
ADDRESS				25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12104

item 9 Film G300 11/16/61 jwk

12091

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>15 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>82 CUMBERLAND</b> d. STREET ADDRESS <b>301 BALTIMORE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ARVELLA</b>		First <b>KILPATRICK</b>		Last <b>NOVEMBER 8 1961</b>		4. DATE OF DEATH Month Day Year	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 1, 1907</b> 9. AGE (in years last birthday) <b>53 5/4 yrs.</b> UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CACAPON BRIDGE, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ORVIS FLETCHER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET LARRICK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-18-8280</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatous</b> 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Annular Carcinoma Transverse Colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Alleg. Mpl.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/7/61</b> , 19..., to <b>11/8/61</b> , 19..., that (I) (we) last saw the deceased alive on <b>11/8/61</b> , 19..., and that death occurred <b>12:10 PM</b> the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>11/8/61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Lutheran Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>near Gore, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>				ADDRESS <b>Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 13 '61</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

15 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

301 BALTIMORE STREET

ARVILLA

KILPATRICK

NOVEMBER 8

FEMALE WHITE

DEC. 1, 1907

CACAPON BRIDGE, W. VA., U.S.A.

ORVIS FLETCHER

MARGARET LARRICK

MEMORIAL HOSPITAL CUMBERLAND, B.

(1)

43:12 PM

RICHARD J. WILLIAMS

122 S. CALHOUN ST., CUMBERLAND, B.

JOHN J. HAYES

RECEIVED INFORMATION DEPARTMENT, DIST. COURT, W. VA.

Cum gratia, Maryland, Nov. 18, 1907

John J. Hayes



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12105 CERTIFICATE OF DEATH 12092											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b> d. STREET ADDRESS <b>39 W. First St., F</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>C.</b> Last <b>KOMATZ</b>						4. DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>61</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-5-03</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Rafferty</b>						14. MOTHER'S MAIDEN NAME <b>Anastasia Scally</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Francis J. Komatz, 39 W. 1st St., Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac dilatation, acute</b> <b>570.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>9 lens, massive</b> (c) <b>2 hrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>2) Dehydration (1) Diabetes mellitus (3) Hypertension (4) Coronary insufficiency</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Frostburg Allegany Md.</b> 20f. City or town (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> 19 <b>51</b> , to <b>11/27</b> 19 <b>61</b> , that (I) <del>was</del> last saw the deceased alive on <b>11/27</b> 19 <b>61</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above. 22a. SIGNATURE <b>Frank T. Harrat</b> M.D. 22b. DATE SIGNED <b>11/28/61</b> 22c. PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b> 22d. ADDRESS <b>26 W. Mechanic St. Frostburg, Md.</b> 22e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11-29-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Bulah H. Montis</b> ADDRESS <b>23 E. MAIN, FROSTBURG, MD.</b> DATE <b>DEC 4 '61</b>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12093

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>113 LENNOX PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERT</b> Middle <b>INA</b> Last <b>E</b> 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>19 61</b> 8. DATE OF BIRTH <b>AUGUST 12, 1905</b> 9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY STEEPE</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE HIMMLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus, Hypertension, Obesity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 1960</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> 19 <b>61</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. James</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>		22d. ADDRESS <b>441 N. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12094

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>	
c. LENGTH OF STAY in 1b <u>60 years</u>		d. STREET ADDRESS <u>227 Offutt St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>227 Offutt St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Addie</u> <u>Madore</u> <u>Lewis</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Nov.</u> <u>1</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sandy Hook, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bissett</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Holt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Oscar J. Lewis, Cumberland, Md.</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD</u> 422.1 DUE TO (b) <u>Fractures of age</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-27</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberland, Md.</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/60</u> to <u>11/61</u> , that (I) (we) last saw the deceased alive on <u>10/28/61</u> , and that death occurred at <u>5:15M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Richard J. Williams</u> M.D.		22b. DATE SIGNED <u>Nov. 2, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard J. Williams</u>		22d. ADDRESS <u>122 S. Centre St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 4, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harper Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Harpers Ferry, W. Va.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12095

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN TB <b>15 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUTH M. LUMAN</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 29, 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1911</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES F. WISLER</b>		14. MOTHER'S MAIDEN NAME <b>BEULAH BOWMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Possible Coronary Thrombosis - Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Chronic Aortic Sclerotic Cardio Vascular Disease with Coronary Hypertension Insufficiency</b> (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14, 1961</b> to <b>Nov. 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1961</b> , and that death occurred at <b>8:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. John Topper</b>		22b. DATE SIGNED <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JOHN TOPPER</b>		22d. ADDRESS <b>HYNDMAN, PA.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lybarger Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Buffalo Mills, Pa. RD#1</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Haigler</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haug</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12109

## CERTIFICATE OF DEATH

12096

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>ALLEGANY</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland (Rural)</b>		d. STREET ADDRESS <b>Rt. # 2 Naves Crossroads</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. # 2 Naves Crossroads</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>EMMA EFFIE MARTIN</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>18</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 21, 1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Terra Alta, W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oscar F. Forquer</b>				14. MOTHER'S MAIDEN NAME <b>Rhoda Jackson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Carl Martin Rt. 2 Naves Crossroads</b>			
17. INFORMANT <b>Mr. Carl Martin Rt. 2 Naves Crossroads</b>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Gen. Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b> <b>5 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Aug.</b> 19 <b>61</b> to <b>18 Nov.</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>16 Nov.</b> 19 <b>61</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Alfred Van Ormer</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>18 Nov. 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. W. A. Van Ormer</b>				22d. ADDRESS <b>122 S. Centre St. Cumberland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

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John J. Nelson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12110

12097

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>223 Carroll St.</b>				d. STREET ADDRESS <b>223 Carroll St.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Helen Mary McKenzie</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 7, 1885</b>	
9. AGE (In years, last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Enoch A. McKenzie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>1112</b>			
17. INFORMANT <b>Mrs. Lawrence Manthey, Cumberland, Maryland</b>				Address <b>1113 161</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Myocardial infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Myocardial infarction</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1961</b> to <b>11/12</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/12</b> , 19 <b>61</b> , and the death occurred at <b>11/13</b> , 19 <b>61</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>George M. Brown</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George M. Brown</b>				22d. ADDRESS <b>1113 161</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein</b>				ADDRESS <b>17 Frederick St. Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			



104117

CERTIFICATE OF MARRIAGE

1907

Allegany

Ward

Allegany

Ward

Ward

223 Carroll St.

223 Carroll St.

November 12, 1907

Helena Mary McKenna

Female

August 7, 1885

Homemaker

Ward, Maryland

Ward, Maryland

Ward, Maryland

Ward, Maryland

*Handwritten notes and signatures, including "Carroll" and "Mary McKenna".*

*Large handwritten signature, possibly "Mary McKenna", across the bottom of the page.*

Nov. 12, 1907, after a full ceremony, Ward, Maryland

Ward, Frederick St. Camp, Md.



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12111  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12098

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>35 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Star Rt.</b>		d. STREET ADDRESS <b>Star Rt.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward Stanley Miller</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 5, 1900</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>21</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Columbus Miller</b>		14. MOTHER'S MAIDEN NAME <b>Alice Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-10-8084</b>	
17. INFORMANT <b>Mrs. Edward S. Miller-Barton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>201X</b> DUE TO (c) <b>201X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1960</b> to <b>Nov. 20, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov. 20, 1961</b> and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William W. Lesh</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM W. LESH, M.D.</b>		22d. ADDRESS <b>90 Main St. 2nd International, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Boal</b>		ADDRESS <b>Westernport, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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CERTIFICATE OF DEATH

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*[Faint, mostly illegible text from a form, likely containing personal and medical details.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12112				CERTIFICATE OF DEATH				12099			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>58 Greene St.,</b>						d. STREET ADDRESS <b>58 Greene St.,</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>FLORA WOLFE MILLER</b>						4. DATE OF DEATH <b>Nov. 14, 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20, 1867</b>		9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius A. Wolfe</b>						14. MOTHER'S MAIDEN NAME <b>Elmira E. Jacobs</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Walter L. Miller</b>		Address <b>Cumberland, Md. 58 Greene St.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>2 - 26, 1956</b> to <b>11 - 14, 1961</b> that (I) (we) last saw the deceased alive on <b>11 - 14, 1961</b> and that death occurred at <b>7:00 PM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph W. Ballin</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>11-15-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin M. D.</b>						22d. ADDRESS <b>62 Greene St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Mausoleum</b>		23d. LOCATION (City, town or county) _____ (State) _____ <b>Cumberland, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>						ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 2, MARYLAND 12113 CERTIFICATE OF DEATH 12100

<b>1. PLACE OF DEATH</b> e. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>184 ORMOND STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>STELLA</b>		<b>MILLER</b>		<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>22</b> Year <b>19 61.</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>FEBRUARY 1, 1892</b>		<b>9. AGE (In years last birthday)</b> <b>69 yrs.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Housework</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>			
<b>13. FATHER'S NAME</b> <b>ELMER MILLER</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH LEWIS</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>213-09-6398</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Hepatitis &amp; Cirrhosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis Myocardial Degeneration</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b>			
<b>22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>2Db. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> <b>Not while at work</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>7/6/60 Cumberland Alleg Md</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11/21/61</b> <b>19</b> <b>to</b> <b>11/27/61</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>11/21/61</b> <b>19</b> <b>and that death occurred at</b> <b>11/27/61</b> <b>AM</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>DR. R. J. WILLIAMS</b>				<b>22b. DATE SIGNED</b> <b>NOV 27 '61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>11-24-1961</b>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FROSTBURG-MEMORIAL PARK</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>FROSTBURG-ALLEG. MD.</b>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph R. Durst, Frostburg, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 27 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>							

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5 DAYS

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101 ORCHARD STREET

GENERAL HOSPITAL  
ST. LOUIS, MISSOURI

MILLER

STAFF

FEBRUARY 1, 1923

WHITE

MARYLAND

OUR HOUSEWORK

HOUSEWORK

SPRING TOWN

CORRELAND

513-02-300 GENERAL HOSPITAL, CORRELAND, MD.

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101. 201 CENTRE STREET, CORRELAND, MD.

DR. R. J. WILLIAMS

*[Faint handwritten text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12114

12101

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>8 DAYS</b>		d. STREET ADDRESS <b>118 WINTON PLACE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARGARET R. MITCHELL</b>		<b>4. DATE OF DEATH</b> <b>11 24 19 61</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/10/86</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady Retired Shoe Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MITCHELL</b>		14. MOTHER'S MAIDEN NAME <b>MARY JOYCE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-5424</b>	
17. INFORMANT <b>John Speir</b>		Address <b>120 Winton Place, Cumb. Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>260X</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 min</b> <b>syn</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14</b> , 19 <b>61</b> , to <b>Nov. 24</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24</b> , 19 <b>61</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clay R. Durrett</b> M.D.		22b. DATE SIGNED <b>11/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLAY DURRETT</b>		22d. ADDRESS <b>236 VIRGINIA AVE. CUMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		25a. REC'D BY REGISTRAR <b>Nov 27 '61</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>	

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12102									
1. PLACE OF DEATH e. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY in 1b <b>60 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			d. STREET ADDRESS <b>1 1027 Penhurst St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1027 Penhurst St.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>John L. Morris</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1901</b>		9. AGE (In years last birthday) <b>60</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John H. Morris</b>					14. MOTHER'S MAIDEN NAME <b>Beulah Norris</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>(If yes give war or date of service)</b>				
17. INFORMANT <b>Mr. George W. Morris, Cumberland, Md</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>DUE TO</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>II-II-61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>					22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>				
23. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					24a. REC'D BY REGISTRAR <b>NOV 14 '61</b>				
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12118

12103

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>68 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		d. STREET ADDRESS <b>S. Utah</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>S. Utah</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Mowbray</b> Last <b>Mowbray</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1892</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Barton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Mowbray</b>				14. MOTHER'S MAIDEN NAME <b>Mary L. Darnley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-5931</b>		17. INFORMANT <b>Maude Mowbray-Barton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Embolus</b> (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>30 Minutes</b> <b>30 Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14, 1961</b> , to <b>Nov. 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 14, 1961</b> , and that death occurred at <b>1:29</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul R. Wilson</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 15, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>				22d. ADDRESS <b>Piedmont, W. Va.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City, town or county) (State) <b>Moscow Mills Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E.S. Boal</b>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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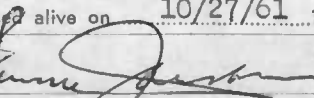
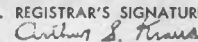


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12117 CERTIFICATE OF DEATH 12104									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>65 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			d. STREET ADDRESS <b>112 N. Smallwood St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>112 N. Smallwood Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>E.</b> Last <b>Naughton</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1877</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Train Master Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Barton, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Michael Patrick Naughton</b>					14. MOTHER'S MAIDEN NAME <b>Ann Dailey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Harold Naughton, Cumberland, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>LEAK Cerebro-vascular accident embolus</b> (c) <b>10 days</b> DUE TO (a), stating the underlying cause last. (c) <b>10 days</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial fibrosis</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10/9/61</b> , 19 <b>11/2/61</b> , that (I) (we) last saw the deceased alive on <b>10/27/61</b> , 19 <b>11:15 P</b> , and that death occurred at <b>11:15 P</b> , from the causes and on the date stated above.									
22a. SIGNATURE  M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/6/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M. D.</b>					22d. ADDRESS <b>50 Pershing St. Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 6, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		25b. REGISTRAR'S SIGNATURE 		

VR A15 (4)  
15M 9/60

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111 E. Smellwood Street  
Chicago, Ill.  
Nov. 1917

Retired from U.S. Army  
at Baltimore, Md.  
April 1917

Mr. Harold Hanson, Chicago, Ill.  
Nov. 1917

Nov. 1917

Nov. 1917

Nov. 1917

Nov. 1917

Nov. 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 HRS. 51 MIN.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1107 NATIONAL HIGHWAY</b>			
3. NAME OF DECEASED (Type or print) <b>BABY BOY NIES</b>				4. DATE OF DEATH <b>NOVEMBER 21, 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>11-21-1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>LOUIS L. NIES</b>				14. MOTHER'S MAIDEN NAME <b>SUE ANN WAGNER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>776X</b> IMMEDIATE CAUSE (a) <b>Prematurity 26-27 weeks</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>21 Nov 1961</b> to <b>2:40 P.M.</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>21 Nov 1961</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Fuller B Whitworth</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. FULLER B. WHITWORTH</b>				22d. ADDRESS <b>123 BEDFORD ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 22, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Clotburg &amp; Hanna</b>	

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MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

BABY

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11-21-1931

WHITE

WHITE

DOB

DOB

CUMBERLAND, MD.

U. S. A.

LOUIS L. RIES

DR. AND RINGER

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. EUGENE B. WHITWORTH

153 BLUDD ST., CUMBERLAND, MD.

Nov. 1, 1931

Nov. 1, 1931

James E. ...

James E. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death, and page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12111

CERTIFICATE OF DEATH

12106

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>19 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>23 GRAND AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>NETTIE</b>		<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>20</b> Year <b>1961</b>					
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>SEPT. 5, 1885</b>	<b>9. AGE</b> (In years last birthday) <b>76 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>76</b> Days <b>76</b>	<b>IF UNDER 24 HRS.</b> Hours <b>76</b> Min. <b>76</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>VIRGINIA - WINCHESTER</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOSEPH BEARINGER</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>SUSAN RAINER</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL,</b> Address <b>CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Right Cerebral Haemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Left Hemiplegia</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 1, 1961</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Nov. 1, 1961</b> <b>to</b> <b>Nov. 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 20, 1961</b> , and that death occurred at <b>8:55 AM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>CLAY E. DURRETT</b>		<b>22b. PHYSICIAN'S NAME</b> (Type) <b>CLAY E. DURRETT</b>		<b>22c. ADDRESS</b> <b>235 VIRGINIA AVE., CUMBERLAND, MD.</b>			
<b>22d. DATE SIGNED</b> <b>11/20/61</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 22, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Mausoleum</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Kraus</b>			

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ALFRED Y. J. J.

CONFIDENTIAL

JOURNAL HOSPITAL

1771

FEBRUARY 1992

JOSEPH BLANKNER

ORIGINAL HOSPITAL

2011.11.12

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18 DAYS

**APPENDIX**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15RM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12120

12107

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE			
ALLEGANY		MARYLAND		MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN TB 40 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 303 WELSH HILL				d. STREET ADDRESS 303 WELSH HILL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR		First M.		Last NORRIS		4. DATE OF DEATH NOVEMBER 2ND, 19 61	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 2ND, 1896	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ET. SHEET MET. WORKER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY NORRIS				14. MOTHER'S MAIDEN NAME SARAH LECHLEITER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES W.W. 1		16. SOCIAL SECURITY NO. 214-07-6369		17. INFORMANT MRS. RHEA NORRIS, 303 WELSH HILL, F.B.G. MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Occlusion Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 60 to Nov 2, 19 61; that (I) (we) last saw the deceased alive on Oct 5 19 61, and that death occurred on Nov 2 19 61, from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 3 1961	
22c. PHYSICIAN'S NAME (Type) W. O. McLane				22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-4-61		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Durst				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE NOV 6 1961	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12121

## CERTIFICATE OF DEATH

13108

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. # 1 Cumberland, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>Rt. # 1 Cumberland, Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Washington Andrews Nycum</b>		4. DATE OF DEATH <b>Nov. 9 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/1881</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Clearville, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Wesley Nycum</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>month year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1959</b> to <b>11/9</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/7</b> , 19 <b>61</b> , and that death occurred at <b>11/9</b> , 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George M. Simons</b>		22b. DATE SIGNED <b>11/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George M. Simons</b>		22d. ADDRESS <b>Baltimore St., Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Christian Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Inglesmith, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>Nov 16 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>James S. House</b>	

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*Handwritten notes:*  
The following is a list of the names of the persons who were present at the meeting held on the 12th of the month of January, 1910.

*Handwritten notes:*  
The following is a list of the names of the persons who were present at the meeting held on the 12th of the month of January, 1910.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it will be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

VR A15 (4)  
15M 9/60

1. PLACE OF DEATH a. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE		MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN lb		50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		02 CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Memorial Hospital		d. STREET ADDRESS		512 Eastern Avenue		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month	
		Dora		Helene		Perdew		Nov.		5	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/22/1899		62 yrs.		Months	
										Days	
										Hours	
										Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				Green Ridge, Maryland		U. S. A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Leonard S. Crabtree		Fannies Meyers									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Charles H. Perdew		512 Eastern Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH		1 day					
4201		DUE TO		Arteriosclerotic cardio-vascular disease		5 years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	
Hour a.m.		19		While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>						(State)	
p.m.											
21. I certify that (I) (this hospital) attended the deceased from		2 - 11		19		59		11 - 5		1961	
saw the deceased alive on		11-2		19		61		and that death occurred at		11a	
22a. SIGNATURE		Ralph W. Ballin		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		Ralph W. Ballin, M.D.		22d. ADDRESS		62 Greene St. Cumberland, Md.		22b. DATE SIGNED		11-7-61	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		11/8/61		Hillcrest Burial Park		Cumberland, Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25e. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Hafer		Cumberland		DATE NOV 9 '61		Arthur S. Kraus					

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11 April 2005



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

12123

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12110

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural # 1 Frostburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>X Rural # 1 Frostburg</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>L.</b> Last <b>Plummer</b>		4. DATE OF DEATH Month <b>11/1/1961</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Cola Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Borden Shaft, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Lavena Loar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>213-09-6463</b>	
17. INFORMANT <b>Mrs. Thomas L. Plummer R.F.D.#1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X Carcinoma of Esophagus with Metastases</b> DUE TO (b) <b>Blunt 2 years</b> DUE TO (c) <b>150X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> 19 <b>60</b> , to <b>8/9</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/9</b> 19 <b>61</b> , and that death occurred at <b>3:52</b> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Calvin Y. Hadidian</b>		22b. DATE SIGNED <b>11/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CALVIN Y. HADIDIAN</b>		22d. ADDRESS <b>ALGONQUIN HOTEL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/3/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12124

Items 8 & 9 Film G301 11/22/61 jwk

12111

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>11 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>			d. STREET ADDRESS <b>237 COLUMBIA STREET</b>		a. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MATILDA</b> Middle <b>SOPHIA</b> Last <b>RICE</b>			4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1961</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/84 1888</b>		9. AGE (In years last birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>ROBERT LEE JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>REBECCA SNYDER JOHNSON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>CHART</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO <b>Acute Gastric distention</b> (b) <b>Gross Negative Bacteremia</b> (c) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unk</b> <b>unk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.					
22a. SIGNATURE <b>DR. MICHAEL L GLICK</b>			22b. DATE SIGNED <b>11-13-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. MICHAEL L GLICK</b>			22d. ADDRESS <b>126 N. SMALLWOOD STREET</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Park</b>	
23d. LOCATION (City, town or county) <b>Cumberland</b>		23e. (State) <b>Maryland</b>		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>			24a. ADDRESS <b>Cumberland Maryland</b>		
25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12125  
12112  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 7, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOX 165, HANCOCK, MARYLAND</b>	
c. LENGTH OF STAY IN 1b <b>ONE DAY</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>			
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
<b>EMORY E. ROBINETTE</b>		<b>11 11 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labo Mines</b>		9. AGE (In years last birthday) <b>68</b> yrs.	11. BIRTHPLACE (County & State, or foreign country) <b>Allegany County Md.</b>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <b>UNITED STATES</b>	
13. FATHER'S NAME <b>HENRY H. ROBINETTE (D)</b>		14. MOTHER'S MAIDEN NAME <b>JANE E. ROBINETTE (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>232226-5899</b>		16. SOCIAL SECURITY NO. <b>Nellie Stabler</b>	
17. INFORMATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-28-61</b> to <b>11-11-61</b> , that (I) (we) last saw the deceased alive on <b>11-11-61</b> , and that death occurred <b>12:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b> M.D.		22b. DATE SIGNED <b>11-13-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>RALPH W. BALLIN M.D.</b>		22d. ADDRESS <b>62 GREENE STREET CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11.15.61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Buck Valley Christian</b>	23d. LOCATION (City, town or county) (State) <b>Buck Valley Fulton Penn.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Glone</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12126

13113

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>				c. LENGTH OF STAY IN 1b <b>10 yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>324 Md. Ave.</b>				d. STREET ADDRESS <b>324 Md. Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Charles Edward Ross</b>				<b>4. DATE OF DEATH</b> <b>Nov. 14 1961</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Mar. 7, 1872</b>	
<b>9. AGE</b> (In years last birthday) <b>89</b>		<b>IF UNDER 1 YEAR</b> Months: Days:		<b>IF UNDER 24 HRS.</b> Hours: Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Westernport, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>James O. Ross</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Guy</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Spanish A. 211-09-0913A</b>		<b>17. INFORMANT</b> <b>Mrs. Marie Lancaster-Winchester, Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degeneration Not Specified as Rheumatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Chronic Myocarditis and Myocardial</b> DUE TO (e), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1957 to Nov. 14, 1961, that (I) (we) last saw the deceased alive on Nov. 10, 1961, and that death occurred at 5 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Paul R. Wilson</b>				<b>22b. DATE SIGNED</b> <b>Nov. 15, 1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Paul R. Wilson</b>	
<b>22d. ADDRESS</b> <b>Piedmont, W. Va.</b>				<b>22e. REC'D BY REGISTRAR</b> <b>NOV 17 '61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/ /61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Philos</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Westernport, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>E. L. Boal</b>				<b>25. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

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*Journal of Management Education*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12127

## CERTIFICATE OF DEATH

12114

Items 8 & 9 Film 8302 12/4/61 1wk

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>30 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BEDFORD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>P.O. BOX 211</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DUANE S. SAXMAN</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 21, 1917</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>KENNAMEAL CO.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>PAUL SAXMAN</b>				14. MOTHER'S MAIDEN NAME <b>EVELYN SCHALL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Ch. Valv. Heart Disease, A.I. and M.I., Rheum.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>1952</b> <b>1948?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>20 Oct. 1961</b> that (I) (we) last saw the deceased alive on <b>23 Nov. 1961</b> , and that death occurred at <b>11:29 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. William A. Van Ormer</b>				22b. DATE SIGNED <b>24 Nov. 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM A. VAN ORMER</b>				22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bedford Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bedford Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Gussit</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

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MEMORIAL HOSPITAL - ALLEGANY, WYOMING

DR. WILLIAM A. VAN DYKE

122 S. CENTRAL STREET, CUMBERLAND, MD.

*Handwritten notes and signatures at the bottom of the page.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12128

## CERTIFICATE OF DEATH

12115

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>31 HRS. 5 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. 1, RIDGELEY, W.VA.</b> d. STREET ADDRESS <b>85X3</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LOIS ANN SELF</b>		4. DATE OF DEATH Month Day Year <b>NOV. 8 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7, 1961</b>
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days <b>1 7</b>	IF UNDER 24 HRS. Hours Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FLOYD G. SELF</b>		14. MOTHER'S MAIDEN NAME <b>LETHA M. ABE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Previaile Prematurity</b> <b>761.5</b> DUE TO <b>Abupta Placenta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>31 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7 Nov 19 61</b> to <b>8 Nov 19 61</b> , that (I) (we) last saw the deceased alive on <b>8 Nov 19 61</b> and that death occurred <b>12:00 NOON</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Leland B. Ransom</b> 22c. PHYSICIAN'S NAME (Type) <b>LELAND B. RANSOM</b>		22b. DATE SIGNED <b>9 Nov 61</b> 22d. ADDRESS <b>63 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/9/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Fort Ashby, W. Va.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 10 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>

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MEMORIAL HOSPITAL



• C. J. O'NEILL

LETTER 5. 24M50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

12116

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/10/1961</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>Box 39, Bedford Road</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Holloway</b> Last <b>Shaw</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/1877</b>
9. AGE (In years lost birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired; Store Keeper- Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Shaw</b>		14. MOTHER'S MAIDEN NAME <b>Mary Heavner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>A594502</b>	
17. INFORMANT <b>P.O. Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Chn. degeneration</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secale</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/10/61</b> to <b>11/13/61</b> , that (I) (we) last saw the deceased alive on <b>11/13/61</b> at <b>5:00 P.M.</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>11/14/1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 16, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. LUKES CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>NOV 17 '61</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert L. Howe</b>	

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(M)

Allegany

Allegany

Allegany

Cumberland

3/10/1961

Cumberland

Allegany County Infirmary

Box 39, Redwood Road

William

Bellows

Shaw

November 13

1961

Male

White

4/10/1977

84

Registered: Storekeeper - Hinton

Cumberland, Maryland U. S. A.

Charles Shaw

Mary Haver

Cumberland, Md.

Allegany County Infirmary records

Dr. Lee T. Mathews

49 Greene St., Cumberland, Md.

3/10/61

11/13/61

11/13/61

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FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12117

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
c. LENGTH OF STAY IN 1b <b>42 years</b>				d. STREET ADDRESS <b>742 Maryland Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Harvey</b> Last <b>Shoemaker</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1888</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b>		IF UNDER 24 HRS. Hours <b>73</b> Min. <b>73</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Savings Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George W. Shoemaker</b>				14. MOTHER'S MAIDEN NAME <b>Anna Jane Baer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>War I</b> <b>War I</b>				16. SOCIAL SECURITY NO. <b>War I</b>			
17. INFORMANT <b>Mrs. Maude Dolan, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Delirium Tremens</b> <b>812X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>(ALCOHOL, also incident to fractured</b> cause last. (c) <b>pelvis sustained when struck by car)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by automobile</b>			
20c. TIME OF INJURY Hour <b>7:00</b> p.m. Month <b>Nov.</b> Day <b>8</b> Year <b>19 61</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>				20f. (City or town) <b>Cumberland, Alleg. Md.</b> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 13, 1961</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 16, 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Oliver Grove Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Oldtown, Md.</b>			
23. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 15 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

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Arthur J. Kravitz

VR A15 (4)  
15M 9/60

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ALLEGEDLY

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U.S.A.

CHARLES SHUTTER

MARY J. FLETCHER

CUMULATIVE

*General Hospital*

*General Hospital*

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*W. F. FLETCHER*

125 E. CENTER ST., CUMULATIVE, MI.

W. F. FLETCHER

*W. F. FLETCHER*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

12132

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12119

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>85yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>East Main Street</b>		d. STREET ADDRESS <b>East Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANDREW M. SMITH</b>		4. DATE OF DEATH <b>11/11/1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/3/1876</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Smith</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Helen Smith, Lonaconing, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial ischemia, atrial fibrillation</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO (c) <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma of Colon</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 1956</b> to <b>Nov. 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>11-9-1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.R. Miles, Jr.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-13-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b> 22d. ADDRESS <b>LONACONING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>11/14/1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			
23d. LOCATION (City, town, or county) (State) <b>Cumberland, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b> ADDRESS <b>LONACONING, MD.</b>			
25a. REC'D BY REGISTRAR <b>NOV 15 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Civilian S. Hanes</b>			

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CERTIFICATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12133					12120								
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)								
a. COUNTY <b>ALLEGANY</b> MARYLAND					a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>								
c. LENGTH OF STAY IN 1b <b>11 DAYS</b>					d. STREET ADDRESS <b>128 SPRINGDALE STREET</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH				
			<b>ALICE</b>		<b>E</b>		<b>SNOEBERGER</b>		Month Day Year <b>NOVEMBER 22 19 61</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 28, 1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Industry</b>					11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND BROWNSVILLE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY FEASTER</b>					14. MOTHER'S MAIDEN NAME <b>JENNIE PHILLIPS</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>212-24-1809</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Coronary Heart Failure - Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerosis</b> } DUE TO <b>Chronic Venous Stasis</b> } (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Aug, 19 60</b>		20g. (County) <b>Nov, 19 61</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug, 19 60</b> to <b>Nov, 19 61</b> , that (I) (we) last saw the deceased alive on <b>Nov 22 19 61</b> , and that death occurred <b>11 20 A.M.</b> from the causes and on the date stated above.										22b. DATE SIGNED			
22a. SIGNATURE <b>G. OVERTON HIMMELWRIGHT</b>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>					22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Church of Brethern</b>				23d. LOCATION (City, town or county) (State) <b>Brownsville, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>				

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CUMBERLAND

MEMORIAL HOSPITAL

150 SPRINGFIELD STREET

ALICE

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WOMEN'S

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FEMALE WHITE

SEPT. 20, 1890

11

HENRY FLEISCH

JENNIE PHILLIPS

CUMBERLAND, MD.

MEMORIAL HOSPITAL

*Forget not that this is the  
Robertson's (Cumberland) House*

E. ORNSTON HILMEWRIGHT

133 VIRGINIA AVE., CUMBERLAND, MD.

NOV. 11, 1911

James E. Scott, Esq., Cumberland, Md.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12121

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## MEDICAL CERTIFICATION

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COMPANY OF THE  
SOUTHERN RAILWAY

*James M. Smith*

RECEIVED AT THE  
OFFICE OF THE

November 22, 1897

James M. Smith, President



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

12135 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12122

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLAYSVILLE</b>	
c. LENGTH OF STAY IN 1b <b>10 Hrs.</b>		d. STREET ADDRESS <b>219 1/2 Wayne Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALFRED J. SPOSSY</b>		4. DATE OF DEATH <b>November 18 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 1913</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>	
11. BIRTHPLACE (State or foreign country) <b>USA, Brierhill, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Anthony Spossey</b>		14. MOTHER'S MAIDEN NAME <b>Rose Glemma</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>191-03-4514</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SKULL FRACTURE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:00 a.m. Nov. 18 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 28, 5 Miles South Ridgeley, Min. W.VA.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/22/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>		22d. LOCATION (City, town, or country) (State) <b>Washington Penna</b>	
23. FUNERAL DIRECTOR <b>Robert J. Abel</b>		24a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

12132

12132

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Robert J. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12136					12123								
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
a. COUNTY <b>ALLEGANY</b>					a. STATE <b>MARYLAND</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					b. COUNTY <b>ALLEGANY</b>								
c. LENGTH OF STAY IN 1b <b>3 DAYS</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>200 N. AVE. POTOMAC PARK</b>								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED			4. DATE OF DEATH			5. AGE (In years last birthday)			6. IF UNDER 1 YEAR				
First <b>DIETER</b>			Last <b>SROKOSIK</b>			Month <b>NOV</b>			Day <b>2</b>				
Year <b>1961</b>													
7. SEX <b>MALE</b>			8. COLOR OR RACE <b>WHITE</b>			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			10. DATE OF BIRTH <b>4-30-46</b>				
11. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>			12b. KIND OF BUSINESS OR INDUSTRY			13. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>			14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
15. FATHER'S NAME <b>GEORGE SROKOSIK</b>			16. MOTHER'S MAIDEN NAME <b>KATHE WOHLERS</b>										
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			18. SOCIAL SECURITY NO. <b>NONE</b>			19. INFORMANT <b>PT'S CHART</b>			Address				
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>204.0</b> IMMEDIATE CAUSE (a) <b>Lymphatic Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>										16. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>August 1, 1961</b> to <b>Nov 2, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov 2, 1961</b> and that death occurred at <b>11/5/61</b> M, from the causes and on the date stated above.										22a. SIGNATURE <b>B. M. Schindler</b>		22b. DATE SIGNED <b>11/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. M. SCHINDLER</b>			22d. ADDRESS <b>43 GREENE STREET</b>			22e. REC'D BY REGISTRAR <b>NOV 7 '61</b>			22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/6/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>			ADDRESS <b>Cumberland Maryland</b>			25a. DATE <b>NOV 7 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12124

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		d. STREET ADDRESS <b>Winchester Road, Cresaptown, Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Winchester Road, Cresaptown, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ida Elizabeth Staggs</b>		4. DATE OF DEATH <b>November 11 19 61</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>10/28/1875</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cresaptown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Isaac Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Emily Dawson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Jackson Staggs (son)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), stating the underlying cause last. DUE TO (b) <b>CORONARY OCCLUSION</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland</b>	(County) <b>Allegany</b>	(State) <b>Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>November 11, 1961</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>	22d. LOCATION (city, town, or country) <b>Cumberland</b>	(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR <b>John J. Hafer</b>		ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

12121

12121



*Handwritten signature or text, possibly "John J. Baker".*

John J. Baker



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12125											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. LENGTH OF STAY IN 1b <b>12 HOURS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.,</b>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
f. STREET ADDRESS <b>322 RACE STREET</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>STURTZ</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 3, 1924</b>		9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>37</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill Room Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>KELLY SPRINGFIELD TIRE</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES STURTZ</b>						14. MOTHER'S MAIDEN NAME <b>BOGGS, BESSIE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>219-14-5794</b>					
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4331 Arrhythmic fibrillation and</b> DUE TO <b>circulatory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(Cause undetermined)</b> DUE TO <b>Rectal bleeding</b> (c) <b>C/M.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>6 months</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/11/61</b> to <b>11/11/61</b> 19 <b>61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>11/11/61</b> 19 <b>61</b> , and that death occurred <b>8:10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. GEORGE SIMONS</b>						22b. DATE SIGNED <b>NOV 15 '61</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b>						22d. ADDRESS <b>ALGONQUIN HOTEL, CUMBERLAND, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kras</b>			

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15M 9/60

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INTERVIEW

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CONCERN

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CONCERN

WARRIOR & MEDICAL

325 WEST STREET

HEALTH HOSPITAL

STURTS

CHARLES

CHARLES

NOVEMBER 10

31

JULY 3, 1912

WHITE

MALE

WILLIAM B. BROWN, JR. SPRINGFIELD THE NORTHERN, CHICAGO, ILL. U. S. A.

BOSS, EDDIE

CHARLES STURTS

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1-24-1912 MEMORIAL HOSPITAL, CUMBERLAND, MD.

*Handwritten notes:*  
The following is a list of names of persons who have been in contact with the above named person since the date of his arrest.  
Listed below are the names of the persons who have been in contact with the above named person since the date of his arrest.

ALLIANCE

11

X

*Handwritten signature:* George Sturts

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

DR. GEORGE STURTS

Nov. 10, 1912 Willingboro Hotel, Camden, N.J.

James I. Brown, Jr., Springfield, Ill.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

Reg. Dist. No. 12126

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Braddock Park</u>		d. STREET ADDRESS <u>221 Center Street</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>L. Thomas, Sr.</u> Middle <u>L.</u> Last <u>Thomas, Sr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Condition, Dept Celanese Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frostburg</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Llewellyn Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>214-07-6363</u>	
17. INFORMANT <u>Ed. L. Thomas, Jr.</u> Address <u>221 1/2 Center St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Brain</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Base of Brain</u> DUE TO (c) <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot self in Rt Temple with 22 Revolver.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in Rt Temple with 22 Revolver.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-15-1961</u> Hour <u>6:00</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W O McLane</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W O McLane MD asst</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 16 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sun Set Memorial Park</u>	22d. LOCATION (City, town, or county) <u>Cumberland</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 20 61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. ...</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12127

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY in 1b <b>Lifetime</b>		d. STREET ADDRESS <b>53 West Main Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>NELLIE</b> <b>JOHNS</b> <b>THOMPSON</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20th</b> Year <b>19 61.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17th, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>School Cafeteria</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Christopher Johns</b>	14. MOTHER'S MAIDEN NAME <b>Mary Carroll</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES. (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>212-18-1589</b>	17. INFORMANT <b>Mr. William J. Thompson, 505 Manor Terrace</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b> <b>30 hrs</b> <b>30 hrs</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that (I) (this hospital) attended the deceased from **1960-19** to **Nov 20, 61**, that (I) (we) last saw the deceased alive on **Nov 19, 61**, and that death occurred at **11:00** A.M. from the causes and on the date stated above.

22a. SIGNATURE <b>W O McLane</b>	22b. DATE SIGNED <b>Nov 21/61</b>
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane M.D.</b>	22d. ADDRESS <b>Frostburg Md</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>
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24. FUNERAL DIRECTOR'S SIGNATURE <b>Reuben H. Montevant</b>	25. REC'D BY REGISTRAR <b>NOV 27 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1

*Handwritten signature*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
12141  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12128

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9/5/1961</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Claud</b> Last <b>Turner</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired; Machinist Helper Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W/Md. Okanoka, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Turner</b>		14. MOTHER'S MAIDEN NAME <b>Anna Kerns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>P.O.Box 599</b>	
17. INFORMANT <b>Allegany County Infirmary records.</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Sudden</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - Cerebral deterioration -</b> DUE TO (c) <b>Aphasia Due to Cerebral Embolism -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/5/1961</b> to <b>11/25/1961</b> , that (I) (we) lost saw the deceased alive on <b>11/25/1961 @ 12:30 P.M.</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>11/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 30 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Thuma</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

12142  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12129  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN TB <b>21 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>VANMETER</b> Last <b>LUKE</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROADER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>MARYLAND</b>	
13. FATHER'S NAME <b>ISSAC VANMETER (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>HANNA McKenzie (DECEASED)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>PATIENTS CHART</b>	
17. INFORMATION <b>PATIENTS CHART</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> 422.1 DUE TO <b>Arteriosclerotic Cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>Arteriosclerotic Cardio-vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11 - 1</b> , 19 <b>61</b> , to <b>11 - 11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11 - 10</b> , 19 <b>61</b> , and that death occurred at <b>3</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>R. W. Ballin</b>		22b. DATE SIGNED <b>11-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem</b>	23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Boal</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 16 '61</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

12113

12113



ALLSOUTH

WATLING

WATLING

CUNNINGHAM

21 DAYS

JUNE

SACRED HEART HOSPITAL

JUNE

WINNIE

NOV.

1911

WHITE

WILEY

JUNE 9, 1911

17

MAYDAY

OUTLINDER

ISSUE NUMBER (DECEASED)

HANNA

(DECEASED)

PATIENTS CHART

10

General Vascular accident

Intermittent Cardiac-vascular disease

3 weeks

3 years

11

11 - 11

11

11 - 1

12

11

11 - 12

11-11-11

x

Dr. George W. Cunningham, M.D.

Dr. John A. Bell, M.D.

Dr. John A. Bell, M.D.

Dr. John A. Bell, M.D.

Dr. John A. Bell, M.D.

Dr. John A. Bell, M.D.

VR A15 (4)  
15M 7/61

## CERTIFICATE OF DEATH

12130

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>114 NEW HAMPSHIRE AVE.</b>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) <b>CATHERINE FRANCES WEBER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>15</b> Year <b>61</b>			
	5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30. 1910</b>	9. AGE (In years last birthday) <b>50 51</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b>15</b> Min. <b>61</b>	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
	13. FATHER'S NAME <b>JOSEPH WEBER</b>			14. MOTHER'S MAIDEN NAME <b>ANNA LUECK</b>				
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-6385</b>		17. INFORMANT <b>PATIENT'S CHART</b>			Address
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <b>11 - 10</b> <b>61</b> to <b>11 - 15</b> <b>61</b> , that (I) (we) last saw the deceased alive on <b>11 - 15</b> <b>19 61</b> , and that death occurred at <b>11a</b> A.M., from the causes and on the date stated above.								
22a. SIGNATURE <b>Ralph W. Ballin</b>				M.D. <b>Ralph W. Ballin, M.D.</b>		22b. DATE SIGNED <b>11-15-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin</b>		22d. ADDRESS <b>62 Greene St Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 18, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town or county) _____ (State) _____ <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REGISTRY REGISTRAR <b>NOV 17 1961</b>		
				25b. REGISTRAR'S SIGNATURE <b>C. H. &amp; Hines</b>				

12130

CERTIFICATE OF DEATH

12131

(M)

ALBANY

WILLIAM

CERTIFICATE

CERTIFICATE

2 DAYS

SACRED HEART HOSPITAL

THE NEW YORK HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12144

12131

1. PLACE OF DEATH a. COUNTY <b>ALLEGANEY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUKE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>430 PRATT STREET</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>CALIFORNIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SAN FRANCISCO</b> d. STREET ADDRESS <b>430 X-2</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE O. WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>Nov. 16 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 13, 1922</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. Dept. Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Macy's</b>	9. AGE (In years last birthday) <b>39</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>LUKE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>George O. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Mammie E. Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. LL</b>	
17. INFORMANT <b>Oliver D. Williams,</b>		Address <b>Luke. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Glomerular nephritis</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 4, 1961</b> to <b>Nov 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 16, 1961</b> , and that death occurred at <b>11am</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James H. Wolverton Jr.</b>		22b. DATE SIGNED <b>Nov. 17, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Wolverton Jr.</b>		22d. ADDRESS <b>Piedmont W.Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Fredlock Jr.</b>		25a. REC'D BY REGISTRAR <b>NOV 20 '61</b>	
ADDRESS <b>Piedmont, W.Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

10121

1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12145  
CERTIFICATE OF DEATH  
12132

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>38 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL. MEMORIAL AVE.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>T.</b> Last <b>WINKLER</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/8/79</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal-Mine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE WINKLER</b>				14. MOTHER'S MAIDEN NAME <b>ROSE M. HOHING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-2993</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> <b>MR. MORIX</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bleeding duodenal ulcer</b> (c) <b>generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>1 yr</b> <b>yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/79</b> to <b>11/2/61</b> , that (I) (we) last saw the deceased alive on <b>11/2/61</b> , and that death occurred at <b>10:02AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. GEORGE SIMONS</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b>				22d. ADDRESS <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Barton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Boul</b>				ADDRESS <b>Westernport, Md.</b>		25. REC'D BY REGISTRAR <b>NOV 28 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL, MEMORIAL AVE.

EDWARD

X

WHITE

WINKLER

12/8/79

MARYLAND

ROSE M. HOLLING

MEMORIAL HOSPITAL, CUMBERLAND, MD.

ALLEGANY

BARTON

38 DAYS

10/1/79

81

U.S.A.

10:05AM

ALCOQUIN HOTEL, CUMBERLAND, MD.

DR. GEORGE STING

WASHINGTON, DC.

BRIDGE

WASHINGTON, DC.

11/20/81

11/20/81

# 1 FOR STATE HEALTH DEPT. (M) 060 1 VS. A15ME 5M 9/60 TO DO: ANY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 12146 12133

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Melvin Charles Wright</b>				4. DATE OF DEATH <b>November 7, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 7, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Train Dispatcher (Ret)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>			
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Wright</b>				14. MOTHER'S MAIDEN NAME <b>Anna Geifarth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>Mrs. Melvin C. Wright, LaVale, Md.</b>			
17. INFORMANT <b>Mrs. Melvin C. Wright, LaVale, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitardalic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitardalic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/10/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>				22d. LOCATION (City, town, or country) (State) <b>Frostburg, Maryland</b>			
23. FUNERAL DIRECTOR <b>Louis Stair Inc.</b>				24a. REC'D BY REGISTRAR <b>NOV 10 '61</b>			
ADDRESS <b>117 Frederick St. Cumb. Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

18133

Allegany

Marshall

Calais

Is Buchanan Ave.

November 7, 1901

January 7, 1904

Proctor, Maryland

Ann's Village

Dr. Edwin C. Wright, Calais, Me.

COCHERRY COCHERRY

COCHERRY COCHERRY

November 7, 1901

Proctor, Me.

Proctor, Maryland

Proctor, Me.

18146

Allegany

Marshall

Is Buchanan Ave.

November 7, 1901

January 7, 1904

Proctor, Maryland

Ann's Village

Unknown

COCHERRY COCHERRY

COCHERRY COCHERRY

Proctor, Me.

Proctor, Me.

Proctor, Me.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
12147  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 'b <b>2/20/1960</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>B.</b> Last <b>Zimmerman</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1873</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Amity, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Clutter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>P.O.Box 599</b> <b>Allegany County Infirmary records.</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocarditis, chr. degenerative.</b> DUE TO (b) <b>Arteriosclerosis. Senile psychosis</b> DUE TO (c) <b>Fracture Right Hip (old)</b> 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/20/60</b> 19 to <b>11/13/61</b> 19, that (I) (we) last saw the deceased alive on <b>11/13/61</b> 19, and that death occurred at <b>1:15 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L. B. Mathews M.D.</b>		22b. DATE SIGNED <b>11/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. B. Mathews M.D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 15, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

1913

CERTIFICATE OF DEATH

1917

Allegany

West Virginia

Allegany

Underland

2/20/1960

Underland

The Wayne Street

Allegany County Infirmary

November 13

Dr. Zimmerman

James

58

12/12/1917

X

Female White

U. S. A.

Smith, Pennsylvania

Honorable

Sarah Gitter

John Kelly

Underland, W.

P.O. Box 590

Allegany County Infirmary records.

11/13/61

2/20/60

11/13/61

11/13/61

19 Greene St., Underland, W.

Noted: Nov. 15, 1961. Underland, W.

Underland, W.